

HSA Bank Employer Discovery Setup Form

REQUIRED FOR ALL ACCOUNTS



Please complete and submit an electronic copy to your health plan along with the new or renewal paperwork. Upon receipt of this form, HSA Bank's Business Relations team will send information to the Employer Contact noted below.

For Health Plan use only: Please return the form to ERsetup@hsabank.com.

Employer: By completing this form, you will gain access to HSA Bank's Employer Administration Site, which is designed to help you manage your Health Savings Account (HSA) program. In addition, you can select to have HSA Bank invoice you directly to pay for your employees' monthly administration fees. If you have questions, please contact us at 855-731-5221, Monday through Friday, 7 a.m. to 7 p.m. CT.

*Required

Account Information						
*Health Plan Name: <input type="checkbox"/> IL <input type="checkbox"/> MT <input type="checkbox"/> NM <input type="checkbox"/> OK <input type="checkbox"/> TX			*BCBS Account Number:			
*BCBS Account Executive						
*Name:		*Phone:	*Email:			
General Employer Information						
*Employer Name:		Employer Federal Tax ID/EIN** <i>(9-digit # must match ID on file at HSA Bank):</i>				
*Employer Physical Address:	*City	*State:	*ZIP:			
Employer Preferred Mailing Address:	City:	State:	ZIP:			
*Employer Contact						
*Name:		*Phone:	*Email:			
*Effective Date of Insurance Health Plan:		*Number of Benefit Eligible Employees:				
Setup Preferences						
Product selection. Check all that apply.						
HSA	HRA	FSA	LPFSA	DCFSA	Mass Transit Account	Parking Account
Fees for all non-HSA products are based on selections and are employer invoiced only						
Who pays HSA account maintenance fees?*** Employer Employee						
***Banking information is required if the <u>employer</u> pays the account maintenance fees. Please fill out the Financial Institution Information on the next page of this form. Discounted \$2.00 HSA Account monthly maintenance fee. Terms of final negotiated contract if applicable, would govern.						
<i>Employer-paid monthly fees are eligible for additional volume and funding discounts with 1,000+ active HSAs. Please contact HSA Bank for a pricing proposal. Terms of the final negotiated contract, if applicable, would govern.</i>						
Integration:						
Utilize integrated enrollment file (from BCBS for both enrollments and terminations of coverage)						

**The Federal Tax Identification Number is assigned to a corporation/business entity for tax purposes. HSA Bank uses it as a unique identifier to connect the employer group to its health plan. Therefore, it is critical that the number be consistent between HSA Bank and the employer group's health plan.

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To be completed by the employer if the employer wants to set up invoicing to pay for its employees' HSA monthly administration fee.

Financial Institution Information (Required if employer is paying fees)			
Financial Institution Name:	Bank Contact:	Phone:	
ACH Routing Number:	Account Number:	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings
You will be emailed a copy of your invoice prior to the 18th of each month. On the 25th, HSA Bank will initiate an ACH pull from the bank account provided in the amount of the invoice. Your monthly invoices and employee list will be available online at the Employer Administration Site. Your signature below certifies the information provided on this form is accurate.			
Authorization Agreement for Direct Payments (ACH Debits)			
I hereby authorize HSA Bank, a division of Webster Bank, N.A., hereinafter called BANK to initiate debit entries to Employer's bank account as indicated above on this form, hereinafter called DEPOSITORY, and to debit the same to such account for payment of the monthly invoiced Health Savings Account service fees for our employees. I acknowledge that the origination of ACH transactions to the Employer's account must comply with the provisions of U.S. law.			
This authorization is to remain in full force and effect until BANK has received written notification from me of its termination in such time and in such manner as to afford BANK and DEPOSITORY a reasonable opportunity to act on it. I certify that I am the authorized signer on the account for the Employer.			
Name(s) (please print):		Title:	
Signature:		Date:	
NOTE: EMPLOYER TERMINATION OR CHANGES TO THIS AUTHORIZATION FOR DEBIT ENTRIES FOR MONTHLY HSA SERVICE FEE INVOICED PAYMENTS CAN BE DONE BY CONTACTING HSA BANK VIA PHONE, SECURE EMAIL (SENT THROUGH THE EMPLOYER ADMINISTRATION SITE) OR U.S. MAIL. HSA BANK MAY TERMINATE THIS AUTHORIZATION OR THE OPTION TO ALLOW THE EMPLOYER TO BE INVOICED FOR THEIR EMPLOYEES' HEALTH SAVINGS ACCOUNT SERVICE FEES UPON 30 DAYS NOTIFICATION. UPON HSA BANK TERMINATION, EMPLOYER'S EMPLOYEES MAY BE CHARGED HSA BANK MONTHLY HEALTH SAVINGS ACCOUNT SERVICE FEES BY DIRECT DEBIT TO THE EMPLOYEES' HSA.			
Key Implementation Dates			
Open Enrollment Start Date:		Open Enrollment End Date:	
<i>Data will be submitted for this employer group</i>			
1 st date enrollment will be submitted:		1 st contribution file date:	
Special Instructions:			
Benefit Consultant/Broker Information			
Name of Organization:		Benefit Consultant/Broker Name:	
Benefit Consultant/Broker Address:		City:	State: ZIP:
Benefit Consultant/Broker Phone Number:		Benefit Consultant/Broker Email Address:	
Bank Use Only			
Health Plan Code:		Marketing Code:	
AIN:	MGA:	Instance: HSC	
Pricing:			